Daniel Siriphongs DDS, PLLC

MEDICAL INFORMATION DATE:____________________________

NAME OF PHYSICIAN: ____ PHONE: __________________________

ADDRESS: ____ ZIP: _____________________________

ARE YOU CURRENTLY RECEIVING MEDICAL CARE? YES NO

IF YES, NATURE OF CARE: ____

LIST **ALL MEDICATIONS** YOU ARE CURRENTLY TAKING: ____

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PHARMACY: ____ PHONE: _________________________

PREVIOUS DENTIST: ____ PHONE: _________________________

REASON FOR LEAVING PREVIOUS DENTIST:____

If female, please answer:		
Y	N	
		Are you taking birth control pills?
		Are you pregnant? # of weeks? _____
		Are you nursing?

Y	N	
		Do you smoke or use tobacco?
		Do you smoke or use any other recreational drugs?
Height:_______________________		
Weight:_______________________		

Y	N	Condition
		ARTIFICIAL JOINTS Date:______
		Abnormal Bleeding
		Alcohol Abuse
		Angina Pectoris
		ARTIFICIAL HEART VALVE
		ASTHMA
		Cancer – Chemotherapy
		Cancer – RADIATION THERAPY
		Congenital Heart Defect
		COPD
		Diabetes
		Difficult to get numb
		Emphysema
		Epilepsy/Seizures
		Fainting Spells
		Fever Blisters
		Headaches/MIGRAINES

Y	N	Condition
		HEART TROUBLE
		HEPATITIS
		HIV or AIDS
		HIGH BLOOD PRESSURE
		History of ENDOCARDITIS
		Kidney Problems
		Liver Disease
		OSTEOPOROSIS
		Psychiatric Problems
		Shingles
		Sickle Cell Disease
		SINUS PROBLEMS
		Stroke
		TAKING DIET PILLS
		Thyroid Problems
		Tuberculosis
		PREMED Needed for Dental

Y	N	Allergies
		Aspirin
		Codeine
		Dental Anesthetics
		Erythromycin
		Hydrocodone
		Latex
		Metals
		Penicillin
		Tetracycline

Other:

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(In Case of Emergency)

NOTIFY:________________________________ RELATION:_______________ PHONE:___________________

HOW DID YOU HEAR ABOUT OUR OFFICE: ____________________________ REFERRED BY? _____________

SIGNATURE (PATIENT/RESPONSIBLE PARTY):____